STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING _____	C 09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	2801 W. 6TH STREET WILMINGTON, DE 19805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 6, 2011 through September 13, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 138. The Stage II survey sample totaled 33 residents.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/6/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview, it was determined that the facility failed to accurately assess the functional feeding status for one of 33 Stage II sampled residents (R8). Findings include: R8 was admitted to the facility on 1/25/07 with diagnosis which included Dementia, Schizophrenia, Osteoarthrosis, and Cerebral Vascular Disease with right sided weakness and Peripheral Vascular Disease. Dining observations on 9/6/11 at 12:30 PM and on 9/8/11 at 12:35 PM revealed that R8 was having difficulty feeding his/her self with the use of the left hand only. Food items from the tray (9/6/11- collard greens, sweet potatoes and apple crisp; 9/8/11- cake) were observed to be on the over bed table, floor and clothing of the resident. R8 did not receive any assistance with feeding from the staff and did not have any adaptive equipment such as a scooped plate or modified utensils on the tray to assist with eating. Review of the Minimum Data Set (MDS) dated 8/29/11 revealed that the resident ' s Functional Status for eating was assessed as independent under self-performance and setup help only for support by staff. Review of the quarterly Interdisciplinary Rehab Screening Form dated 8/30/11 documented for ADL (Activities of Daily Living) that the resident was dependent for dressing, toileting and feeding. On 9/9/11 at 2:10 PM, R8's quarterly rehab screening forms (6/14/11 and 8/30/11) and	F 278		

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F 278	Continued From page 2 progress notes (date of service 1/6/2011-4/8/2011) were reviewed with the E8 (Occupational Therapist/OT). E8 confirmed that the April 2011 discharge summary documented under Functional Outcomes for Self Feeding as Total Dependence with attempt to initiate and the 8/30/11 quarterly also documented dependent with feeding. E8 stated that Total Dependence meant that the resident was a feeder. During an interview with the resident on 9/6/11 at 12:30 PM, the resident requested assistance with removing the apple crisp from a plastic cup and on 9/8/11 at 12:35 PM, the resident requested assistance with eating a piece of cake and reaching a can of soda. When asked if the resident had requested assistance with feeding from staff in the past, the resident answered yes. The resident also stated that sometimes the staff provided assistance with feeding and at other times they did not. On 9/8/11 at 12:40 PM, E9 (nurse) stated that R8 always spills food while eating and providing assistance with the meals had not been considered or referred to the therapy department for evaluation. On 9/9/11 at 1:50 PM, E4 (nurse) stated that R8 does spill food while eating and that when a resident is spilling food while eating, it would be appropriate to place a rehab consult to the OT department for evaluation. E4 also agreed that the resident required more assistance than setup only as assessed on the current MDS. On 9/9/11 at 2:00 PM, E7 (Certified Nursing Assistant/CNA) confirmed that the CNA's always have to clean up food off the floor and on the resident after eating meals. E7 also stated that R8 is a setup only and not an assist with feeding.	F 278	F278 1. A therapy screen was obtained for resident R8 to reevaluate functional feeding status. 9/12/11 2. A random audit was completed by the DON on all units to ensure residents were receiving the required assistance at meal times. 9/13/11 3. All staff will be in serviced by the Staff Educator on the importance of referring residents with feeding difficulties to therapy and providing the required amount of assistance at meal times. 10/31/11 4. DON/Designee will complete a Quarterly QI audit to ensure that residents are receiving the correct assistance at meal times. Findings will be presented to the Quality Improvement Committee until substantial compliance is achieved. Ongoing	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 3 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview, it was determined that the facility failed to review and revise care plans regarding the functional status for feeding and fluid for two of 33 Stage II sampled residents (R8 and R149). Findings include: 1. R8 was admitted to the facility on 1/25/07 with diagnosis which included Dementia, Schizophrenia, Osteoarthrosis, and Cerebral Vascular Disease with right sided weakness and Peripheral Vascular Disease. Review of the	F 280		

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F 280	Continued From page 4 resident's care plans initiated on 8/30/11 failed to have goals or interventions which addressed R8's functional feeding status. Dining observations on 9/6/11 at 12:30 PM and on 9/8/11 at 12:35 PM revealed that R8 was having difficulty feeding his/her self with the use of the left hand only. Food items from the tray (9/6/11- collard greens, sweet potatoes and apple crisp; 9/8/11- cake) were observed to be on the over bed table, floor and clothing of the resident. The resident did not receive any assistance with feeding from the staff and did not have any adaptive equipment such as a scooped plate or modified utensils on the tray to assist with eating. Review of the Minimum Data Set (MDS) dated 8/29/11 revealed that R8's Functional Status for eating was assessed as independent under self-performance and setup help only for support by staff. Review of the quarterly Interdisciplinary Rehab Screening Form dated 8/30/11 documented for ADL (Activities of Daily Living) that the resident was dependent for dressing, toileting and feeding. Review of care plan "PA #13c" documented a nursing intervention to refer to OT (Occupational Therapy) for feeding difficulties with the resident. This intervention was initiated on 9/3/09. The care plan did not indicate that the resident had any difficulties with feeding or that the OT had been consulted. The last revision date was 8/30/11. During an interview on 9/6/11 at 12:30 PM, R8 requested assistance with removing the apple crisp from a plastic cup and on 9/8/11 at 12:35 PM, R8 requested assistance with eating a piece	F 280	F280 #1 1. Resident R8's care plan was reviewed and revised to reflect the resident's current status after the therapy screen was completed to assess the residents feeding s status. 2. A random audit of care plans was completed to ensure the accuracy of feeding status assessment and documentation. 3. All nurses will be in serviced on care planning accuracy and revision of ADL status. 4. DON/Designee will complete a Quarterly QI to monitor the accuracy of ADL status documentation on care plans and report findings at the Quarterly QI meeting until substantial compliance is met.	9/12/11 9/13/11 10/31/11 Ongoing

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F 280	Continued From page 5 of cake and reaching a can of soda. When asked if the resident had requested assistance with feeding from staff in the past, R8 answered yes. The resident also stated that sometimes the staff provided assistance with feeding and at other times they did not. On 9/9/11 at 1:50 PM, E4 (nurse) reviewed the resident's nutritional assessments, 8/29/11 MDS, OT discharge summary from 4/16/11 and meal intake forms for the week. E4 stated that R8 does spill food while eating and that when a resident is spilling food while eating, it would be appropriate to place a rehab consult to the OT department for evaluation. E4 confirmed that the MDS assessed the resident as set up only for support and the current care plans did not indicate the resident's functional feeding status. E4 also stated that a rehab consult had not been made for R8. 2. R149's monthly physician's orders, dated 6/22/11, included an order for a 1200 ml (milliliter) fluid restriction. Review of R149's Dietary Progress Note, dated 8/18/11stated, "Nursing reports res (resident) non-compliant c (with) fluid restriction..." R149's care plan, initiated on 7/1/11 and entitled, "...Nutritional status: Resident at risk for alteration in nutrition status R/T (related to) ESRD (End Stage Renal Disease)... dx (diagnosis)...Receives a therapeutic diet and has the need for a fluid restriction..." Review of the interventions included, "Maintain 1200 ml fluid restriction..." However, the facility failed to revise this or any of his other care plans to address R149's noncompliance with his	F 280	F280 #2 1. Resident R149's care plan was revised to include non-compliance with fluid restrictions. 9/13/11 2. All residents currently on fluid restrictions were audited by the DON to ensure compliance with restriction and accurate documentation of non-compliance. 9/14/11 3. All staff will receive in servicing on the importance fluid restriction and correct documentation of adherence to fluid restriction/non compliance with restriction. 10/31/11 4. The Dietician will complete a Quarterly QI audit of compliance with and documentation of fluid restriction until substantial compliance is achieved. Results will be reported at the Quarterly I meeting. Ongoing	

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F 280	Continued From page 6 fluid restriction. During an interview on 9/13/11 at 11:10 AM, E7 (nurse) stated that R149 is often non compliant with his fluid restriction when in the dining room. E7 reviewed R149's care plans and confirmed that they had not been revised to address R149's noncompliance. During an interview on 9/13/11, E8 (registered dietitian) acknowledged that she was aware R149 was non compliant and had previously discussed the importance of adherence to the fluid restriction with him. E8 acknowledged that R149's care plan did not reflect his current status of noncompliance and stated that she would revise it. A copy of the revised care plan was provided to the survey team. The facility failed to revise R149's care plan until after the survey team brought it to their attention.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interview, it was determined that the facility failed to ensure that one of 33 Stage II sampled residents with decreased functional abilities received assistance with feeding (R8). Findings include:	F 312		

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F 312	Continued From page 7 R8 was admitted to the facility on 1/25/07 with diagnosis which included Dementia, Schizophrenia, Osteoarthrosis, and Cerebral Vascular Disease with right sided weakness and Peripheral Vascular Disease. Dining observations on 9/6/11 at 12:30 PM and on 9/8/11 at 12:35 PM revealed that R8 was having difficulty feeding his/her self with the use of the left hand only. Food items from the tray (9/6/11- collard greens, sweet potatoes and apple crisp; 9/8/11- cake) were observed to be on the over bed table, floor and clothing of the resident. The resident did not receive any assistance with feeding from the staff and did not have any adaptive equipment such as a scooped plate or modified utensils on the tray to assist with eating. Review of the Minimum Data Set (MDS) dated 8/29/11 revealed that the resident's Functional Status for eating was assessed as independent under self-performance and setup help only for support by staff. Review of the quarterly Interdisciplinary Rehab Screening Form dated 8/30/11 documented for ADL (Activities of Daily Living) that the resident was dependent for dressing, toileting and feeding. During an interview with the resident on 9/6/11 at 12:30 PM, R8 requested assistance with removing the apple crisp from a plastic cup and on 9/8/11 at 12:35 PM, R8 requested assistance with eating a piece of cake and reaching a can of soda. When asked if the resident had requested assistance with feeding from staff in the past, R8 answered yes. The resident also stated that sometimes the staff provided assistance with	F 312	F312 1. A therapy screen was obtained for resident R8 to reevaluate functional feeding status. 2. A random audit was completed by the DON on all units to ensure residents were receiving the required assistance at meal times. 3. All staff will be in serviced by the Staff Educator on the importance of referring residents with feeding difficulties to therapy and providing the required amount of assistance at meal times. 4. DON/Designee will complete a Quarterly QI audit to ensure that residents are receiving the correct assistance at meal times. Findings will be presented to the Quality Improvement Committee until substantial compliance is achieved.	9/12/11 9/13/11 10/31/11 Ongoing

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F 312	Continued From page 8 feeding and at other times they did not. On 9/9/11 at 1:50 PM, E4 (nurse) stated that R8 does spill food while eating and that when a resident is spilling food while eating, it would be appropriate to place a rehab consult to the OT department for evaluation. E4 also agreed that the resident required more assistance than setup only as assessed on the current MDS. On 9/9/11 at 2:00 PM, E7 (Certified Nursing Assistant/CNA) confirmed that the CNA's always have to clean up food off the floor and on the resident after eating meals. E7 also stated that the resident is a setup only and not an assist with feeding.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain the environment free from accidents hazards, as evidenced by an accessible and unlocked treatment cart, extension cords on floors posing a tripping hazard, and an unlocked shower room on the dementia unit. Findings include: 1. Observations made on 9/6/11 revealed a	F 323		

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F 323	Continued From page 9 treatment cart on the Westover unit unlocked with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E10 (Nurse Supervisor) on 9/6/11, she confirmed the cart needed to be locked. 2. An observation of R49's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 3. An observation of R123's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 4. An observation of R137's room during the environmental tour on 9/8/11 revealed a long phone cord on the floor that posed a potential tripping hazard. The phone cord was in the walking space of the floor in front of the bed. In interviews with E11 on 9/8/11, he confirmed the finding. E11 was observed relocating the cords each time. 5. Observation on 9/6/11 at 8:50 AM of the second floor Lancaster unit (locked unit) revealed an unlocked shower room. In an interview with E17 (nurse) immediately after the observation, she stated that the door was to be locked. E17 went to check the door and stated something was	F 323	F323 #1 1. The treatment cart was immediately locked when identified as unsecured. 2. All medication/treatment carts were checked by the DON to ensure locks were in place. 3. In servicing will be provided to all nursing staff on the importance of securing all treatment/medication carts. 4. A Quarterly QI will be initiated by the DON/Designee to ensure that all treatment/medication carts remain locked when not in use until substantial compliance is met. Findings will be presented to the Quality Improvement Team.	9/6/11 9/6/11 10/31/11 Ongoing

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 9 treatment cart on the Westover unit unlocked with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E10 (Nurse Supervisor) on 9/6/11, she confirmed the cart needed to be locked. 2. An observation of R49's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 3. An observation of R123's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 4. An observation of R137's room during the environmental tour on 9/8/11 revealed a long phone cord on the floor that posed a potential tripping hazard. The phone cord was in the walking space of the floor in front of the bed. In interviews with E11 on 9/8/11, he confirmed the finding. E11 was observed relocating the cords each time. 5. Observation on 9/6/11 at 8:50 AM of the second floor Lancaster unit (locked unit) revealed an unlocked shower room. In an interview with E17 (nurse) immediately after the observation, she stated that the door was to be locked. E17 went to check the door and stated something was	F 323	#2 1. Electrical cord identified in R49's room during environmental tour was placed behind the bed immediately. 2. Nursing staff will conduct safety rounds on their units to ensure any and all cords are properly placed to avoid tripping hazards. In-service will be provided to all staff. 3. Random observations will be conducted by Maintenance Director and/or Designee weekly to ensure cords are properly placed. 4. Maintenance Director will report findings to QI committee quarterly until substantial compliance is achieved.	9/8/11 10/31/11 10/31/11 Ongoing

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 9 treatment cart on the Westover unit unlocked with contents accessible to residents and visitors. The cart stored medicated ointments. In an interview with E10 (Nurse Supervisor) on 9/6/11, she confirmed the cart needed to be locked. 2. An observation of R49's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 3. An observation of R123's room during the environmental tour with E11 (Maintenance Director) and E12 (Environmental Director) on 9/8/11 revealed a black bed electric cord on the floor that posed a potential tripping hazard. The electric bed cord was in the walking space of the floor in front of the bed. 4. An observation of R137's room during the environmental tour on 9/8/11 revealed a long phone cord on the floor that posed a potential tripping hazard. The phone cord was in the walking space of the floor in front of the bed. In interviews with E11 on 9/8/11, he confirmed the finding. E11 was observed relocating the cords each time. 5. Observation on 9/6/11 at 8:50 AM of the second floor Lancaster unit (locked unit) revealed an unlocked shower room. In an interview with E17 (nurse) immediately after the observation, she stated that the door was to be locked. E17 went to check the door and stated something was	F 323	#3 1. Electrical cord identified in R123's room during environmental tour was placed behind the bed immediately. 9/8/11 2. Nursing staff will conduct safety rounds on their units to ensure any and all cords are properly placed to avoid tripping hazards. In-service will be provided to all staff. 10/31/11 3. Random observations will be conducted by Maintenance Director and/or Designee weekly to ensure cords are properly placed. 10/31/11 4. Maintenance Director will report findings to QI committee quarterly until substantial compliance is achieved. Ongoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING _____	C 09/13/2011

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F 323	Continued From page 10 wrong with the locking mechanism and that maintenance would be called.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and interviews, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions in the kitchen on 9/6/11. Findings include: 1. On 9/6/11 at 10:15 AM, during a second visit of the kitchen when staff were using the dishwasher, the internal temperature readings of the dish machine were 147°F. The external wash and rinse gauges were reading 140°F and 150°F respectively. This was below the 160°F required for proper sanitization. Additionally, the plates were coming out of the dishwasher with encrusted debris. Dietary staff (E14 and E15) were observed placing the soiled cleaned plates in the racks through the dishwasher machine at least two to three times. In an interview with E14 on 9/6/11, E14 was	F 371	#1 1. All dishes observed and not observed were placed through dish machine a second time after findings of booster not engaged. 9/6/11 2. In-service was provided to all dietary staff on proper procedure for setting up the dishwasher. Dietary Aide #2 will verify Dietary Aide #1's recorded temperatures before dishwashing is conducted to ensure booster has been turned on and temp is within code. 9/21/11 3. Temperature log will be reviewed weekly and random audits conducted by Food Service Director and/or Designee to ensure accurate temps are recorded. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing	

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F 371	Continued From page 11 asked by the surveyor if the dishwasher used a booster to heat up the water. The staff was observed asking E16 (Cook) if the booster was on. E16 was then observed turning the booster on. At 10:25 AM, the internal temperature reading of the dishwasher was 160°F, an increase from 147°F, after the booster was turned on. In an interview with E13 (Food Services Director) on 9/6/11 at 2:30 PM, she stated that the staff that set up and turned the dishwasher machine on was supposed to turn the booster on and log the outside wash and rinse temperatures. E13 confirmed this finding. The dietary procedure entitled, "Dish Machine - High Temperature" was reviewed. 2. Observation of the kitchen steam table on 9/6/11 at 11:20 AM revealed the following food temperatures: - the mechanical chicken = 131 degrees Fahrenheit (F), - the puree chicken to = 112°F, - the puree yam = 120°F, - the puree cauliflower = 125°F. All these temperatures were below the required 135 F per the 2011 Delaware Food Codes. E16 (Cook) proceeded to plate the mechanical chicken and handed the plate to the serving staff, at which point the surveyor stopped the staff from serving the food. E16 was then observed removing the pans of mechanical chicken, puree chicken, puree yam and puree cauliflower off the steam table and placing it inside the steamer. In an interview with E16 and E13 (Food Service	F 371	#2 1. Food temperature was brought up to code before serving the residents. 9/6/11 2. Food temperatures will be recorded by Cook on temperature log. Second Cook and/or Designee will check temperature accuracy before tray line is started. 10/6/11 3. Temperature log will be reviewed weekly and random audits conducted by Food Service Director and /or Designee to ensure accurate temperatures are within code. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing	

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F 371	Continued From page 12 Director) on 9/6/11, E16 stated that he used a different process than he normally uses. He stated that he usually used the steamer to keep the food warm rather than the convection oven which he used today. E16 stated he did not test the food for temperatures when he removed the food from the oven and placed it in the steam table. The facility had no cooking temperature logs for review. E13 and E16 on 9/6/11 confirmed this finding. The facility failed to hold food under sanitary conditions at the kitchen steam table per the Food Code requirements. 3. An observation on 9/6/11 at 8:55 AM of the clean resident coffee cups (4 of 8) stored on the ready to use tray revealed the cups were wet on the food contact surface area of the cup. On 9/6/11 at 10:30 AM, an observation of the dishwasher operation revealed the food trays were stacked dripping wet as the staff stored them coming off the dishwasher exit. In an interview with E13 (Food Service Director) on 9/6/11, she confirmed this finding. She stated they have no space in the kitchen to place additional equipment to air dry the dish ware properly. 4. An observation during the kitchen tour on 9/6/11 at 8:30 AM revealed a large garbage barrel containing food refuse was uncovered. The lid was observed on the floor and the barrel not in use. The dietary staff was observed serving food for breakfast. On 9/12/11 at 2:43 PM, an observation of the kitchen area revealed one of two refuse barrels with food refuse was	F 371	#3 1. Cups identified as being wet were not used for residents at meal time. 9/6/11 2. A second set of cups will be purchased to create an A and B grouping. All dietary staff will be in serviced on the rotation of groupings for use at meal time. 9/21/11 3. Weekly random audits will be conducted by Food Service Director and/or Designee to ensure cups are being rotated in their groupings. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing	

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F 371	Continued From page 13 uncovered. One of the two barrels was not in use at the time. A few flies were observed on the edge of the refuse barrels. This created a potential for pest harborage.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to dispose of expired medications. Findings include: 1. On 9/9/11 at 10:50 AM, inspection of the locked medication room was completed on the Westover unit with E3 (nurse). Inspection of the medication refrigerator revealed one expired (June 2011) vial of influenza vaccine. E3 acknowledged that the vaccine was expired. 2. On 9/9/11 at 11:00 AM, inspection of the locked medication room was completed on the Lancaster unit with E5 (nurse). Inspection of the medication refrigerator revealed one expired (June 2011) vial of influenza vaccine. E5 acknowledged that the vaccine was expired.	F 431	F431 #1 & #2 1. Both expired influenza vaccines were discarded when identified. 2. All medication refrigerators and medication carts were audited by the DON to ensure all medications/vaccines were in date. 3. The refrigerators will be inspected weekly by the Unit Managers to ensure that all expired medications/vaccines are discarded. 4. The DON/Designee will audit the refrigerators/medication carts for Quarterly QI to ensure compliance until substantial compliance is reached.	9/9/11 9/9/11 9/12/11 Ongoing
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to obtain laboratory services to meet the needs of one (R109) out of 33 sampled residents. Findings include:	F 502		

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F 502	Continued From page 15 The 9/11 monthly physician's order sheet (POS) stated that R109 was to have a lipid profile, liver function tests (LFTs) and a basic metabolic panel (BMP) drawn every 6 months (August & February). Review of R109's clinical record revealed that on 2/26/11 a lipid profile and LFTs were drawn. A BMP was not drawn until 5/18/11. Further review revealed that the clinical record lacked evidence of the lipid profile, LFTs and BMP having been drawn in August, 2011. During an interview with E4 (nurse) on 9/8/11 at 2:30 PM, E4 confirmed that the labs had not been obtained as ordered.	F 502	F502 1. The missing labs were obtained when identified as being omitted. 9/8/11 2. A random audit was completed on all units by the DON to ensure that all ordered labs were obtained. 9/9/11 3. In servicing will be provided by the Staff Educator to all nurses on following up on lab orders. 10/31/11 4. A Quarterly QI will be initiated and monitored by the DON/Designee to ensure that all ordered labs are appropriate, have been obtained and that the results are available. This QI will continue until substantial compliance is reached. Ongoing	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain clinical records that were	F 514		

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F 514	Continued From page 16 complete and accurately documented for two (R8 and R149) out of thirty-three (33) Stage II sampled residents. Findings include: 1. R8 was admitted to the facility on 1/25/07 with diagnosis which included Dementia, Schizophrenia, Osteoarthrosis, and Cerebral Vascular Disease with right sided weakness and Peripheral Vascular Disease. Review of the Dupont Unit Meal and Intake Sheet dated 9/6/11 documented that R8 consumed 100 percent (%) % of the meal for lunch. Dining observations on 9/6/11 at 12:30 PM revealed that R8 did not consume 100% of the lunch meal. Collard greens, sweet potatoes and apple crisp were observed on the resident ' s clothing, over bed table and floor. Approximately 20% of the resident's meal was not consumed secondary to spillage. On 9/9/11 at 2:00 PM, E7 (Certified Nursing Assistant/CNA) confirmed that the CNA's always have to clean up food off the floor and on the resident after eating meals. E7 also stated that the spillage of food should not be counted as part of the percentage intake. 2. R149's 8/11 POS (Physician Order Sheet) revealed that he was ordered to be on a 1200 ml (milliliter) fluid restriction. Review of R149's August 2011 "Food Intake Record" revealed inaccurate documentation for the total fluid amounts at meals times. On 8/12/11, 8/16/11, and 8/20/11 documentation revealed that R149 drank 100% of his Nepro (supplement) which equaled 240 ml, yet the total amount consumed for dinner liquids was incorrectly documented as only 120 ml. On 8/28/11, it was documented that R149 consumed 100% of his supplement (240	F 514	F514 #1 1. The meal intake record was reviewed by the Unit Manager and DON. 9/9/11 2. A random audit was conducted by the DON on all units to ensure the accuracy of meal percentage documentation. 9/12/11 3. In servicing will be provided by the Staff Educator on meal percentage calculation and documentation. 10/31/11 4. The Staff Educator/Designee will complete a Quarterly QI on meal percentage calculation and document on accuracy until substantial compliance is achieved. Ongoing #2 1. The meal/fluid intake record was reviewed by the Unit Manager and DON. 9/13/11 2. A random audit was completed by the DON on all units to ensure the accuracy of fluid intake documentation. 9/14/11 3. In-servicing will be provided to all nursing staff by the Staff Educator on fluid consumption calculation and documentation. 10/31/11 4. The Staff Educator/Designee will complete a Quarterly QI on fluid consumption documentation until substantial compliance is met. Ongoing	

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F 514	Continued From page 17 ml) but incorrectly documented that R149 "R" (refused) fluid intake at his supper meal. On 8/30/11, for the breakfast meal, R149 drank 100% of his supplement (240 ML) but total fluids consumed at that meal were incorrectly documented as 120 ml. During an interview on 9/13/11, E6 (nurse) stated that the total fluid consumption for each meal should include any supplement consumed and these totals did not reflect that. The facility failed to accurately document R149's total fluid consumption for each meal.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Parkview Nursing Home

DATE SURVEY COMPLETED: September 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility from September 6, 2011 through September 13, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 138. The Stage II survey sample totaled 33 residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 9/13/11, F278, F280, F312, F323, F371, F431, F502, and F514.	
3201.7.5	**Kitchen and Food Storage Areas.**	

Provider's Signature [signature] Title [signature] Date 10/6/11

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	Facilities shall comply with the Delaware Food Code. **3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding.** **(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food) shall be maintained:** **(1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130oF) or above; P or** **(2) At 5°C (41°F) or less.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 9/13/11, F371, Example 2. **4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature.** (A) The temperature of the wash solution in spray type warewashers that use hot water to sanitize may not be less than: (1) For a stationary rack, single temperature machine, 74°C (165°F); (2) For a stationary rack, dual temperature machine, 66°C (150°F); (3) For a single tank, conveyor, dual temperature machine, 71°C (160°F); or (4) For a multitank, conveyor,	#2 1. Food temperature was brought up to code before serving the residents. 9/6/11 2. Food temperatures will be recorded by Cook on temperature log. Second Cook and/or Designee will check temperature accuracy before tray line is started. 10/6/11 3. Temperature log will be reviewed weekly and random audits conducted by Food Service Director and /or Designee to ensure accurate temperatures are within code. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing

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	multitemperature machine, 66°C (150°F). **4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures.** **(A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90°C (194°F), or less than:** **(1) For a stationary rack, single temperature machine, 74°C (165°F); or** **(2) For all other machines, 82°C (180°F).** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 9/13/11, F371, Example 1. **4-901.11 Equipment and Utensils, Air-Drying Required.** **After cleaning and sanitizing, equipment and utensils:** **(A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and** **(B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.**	#1 1. All dishes observed and not observed were placed through dish machine a second time after findings of booster not engaged. 9/6/11 2. In-service was provided to all dietary staff on proper procedure for setting up the dishwasher. Dietary Aide #2 will verify Dietary Aide #1's recorded temperatures before dishwashing is conducted to ensure booster has been turned on and temp is within code. 9/21/11 3. Temperature log will be reviewed weekly and random audits conducted by Food Service Director and/or Designee to ensure accurate temps are recorded. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing #3 1. Cups identified as being wet were not used for residents at meal time. 9/6/11 2. A second set of cups will be purchased to create an A and B grouping. All dietary staff will be in serviced on the rotation of groupings for use at meal time. 9/21/11 3. Weekly random audits will be conducted by Food Service Director and/or Designee to ensure cups are being rotated in their groupings. 10/6/11 4. Food Service Director will report to QI committee results of audits until substantial compliance is achieved. Ongoing

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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	This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 9/13/11, F371, Example 3.	